Lewis Dental Group

Patient Name:_____Birth Date: _____ Today's Date:_____

- Are you currently under a physician's care; been recently hospitalized or had a head/neck injury?
  ☐ No If yes:
- Have you ever taken Fosamax, Boniva, Actonel, or any medication containing bisphosphonates? ☐ No If yes:
- Are you required to take antibiotic premedication for dental procedures? ☐ No If yes:
- Do you use controlled substances? ☐ Yes ☐ No
- Do you use marijuana (cannabis)? ☐ Yes ☐ No
- Do you use tobacco? ☐ Yes ☐ No
- Have you ever had a sleep study? ☐ Yes ☐ No
- Do you us a CPAP machine? ☐ Yes ☐ No
- Have you had any orthodontic treatment? ☐ Yes ☐ No
- Do you like your smile? ☐ Yes ☐ No

Women: Are you pregnant/trying to get pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No
Are you taking oral contraceptives? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Acetaminophen ☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Ibuprofen ☐ Latex ☐ Penicillin
☐ Local Anesthetics ☐ Metal ☐ Pine Nuts ☐ Sulfa Drugs ☐ None
Other:

Please list all medications and supplements you are currently taking, including blood thinners:

Health Conditions: Do you have, or have you had any of the following?

☐ AIDS/HIV	☐ Anaphylaxis	☐ Anemia	☐ Angina
☐ Arthritis/Gout	☐ Artificial Heart Valve	☐ Artificial Joint	☐ Asthma
☐ Blood Disease	☐ Bruise Easily	☐ Cancer	☐ Chemotherapy
☐ Chest Pains	☐ Cold Sores/Fever Blisters	☐ Congenital Heart Disease	☐ Convulsions
☐ Diabetes	☐ Drug Addiction/Alcoholism	☐ Easily Winded	☐ Emphysema
☐ Epilepsy or Seizure	☐ Excessive Bleeding	☐ Fainting Spells/Dizziness	☐ Frequent Cough
☐ Frequent Headaches	☐ Glaucoma	☐ Hay Fever	☐ Hearing Problems
☐ Heart Attack/Failure	☐ Heart Murmur	☐ Heart Pacemaker	☐ Heart Trouble/Disease
☐ Hemophilia	☐ Hepatitis A	☐ Hepatitis B or C	☐Herpes
☐ High Blood Pressure	☐ High Cholesterol	☐ Hypoglycemia	☐ Irregular Heartbeat
☐ Kidney Problems	☐ Leukemia	☐ Liver Disease	☐ Low Blood Pressure
☐ Mitral Valve Prolapse	☐ Osteoporosis	☐ Pain in Jaw Joints	☐ Radiation Treatments
☐ Recent Weight Loss	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sexually Transmitted Disease	☐ Sinus Trouble	☐ Stomach/Intestinal Disease	☐ Stroke
☐ Thyroid Disease	☐ Tuberculosis	☐ Tumors or Growths	☐Ulcers

Physician_____ Last Exam Date _____

Previous Dentist_____ Last Exam Date _____

Have you ever had an illness not listed? If yes:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

Signature X _____ Date_____